MILLIMAN REPORT

Group health rating and underwriting survey: Current practices in India

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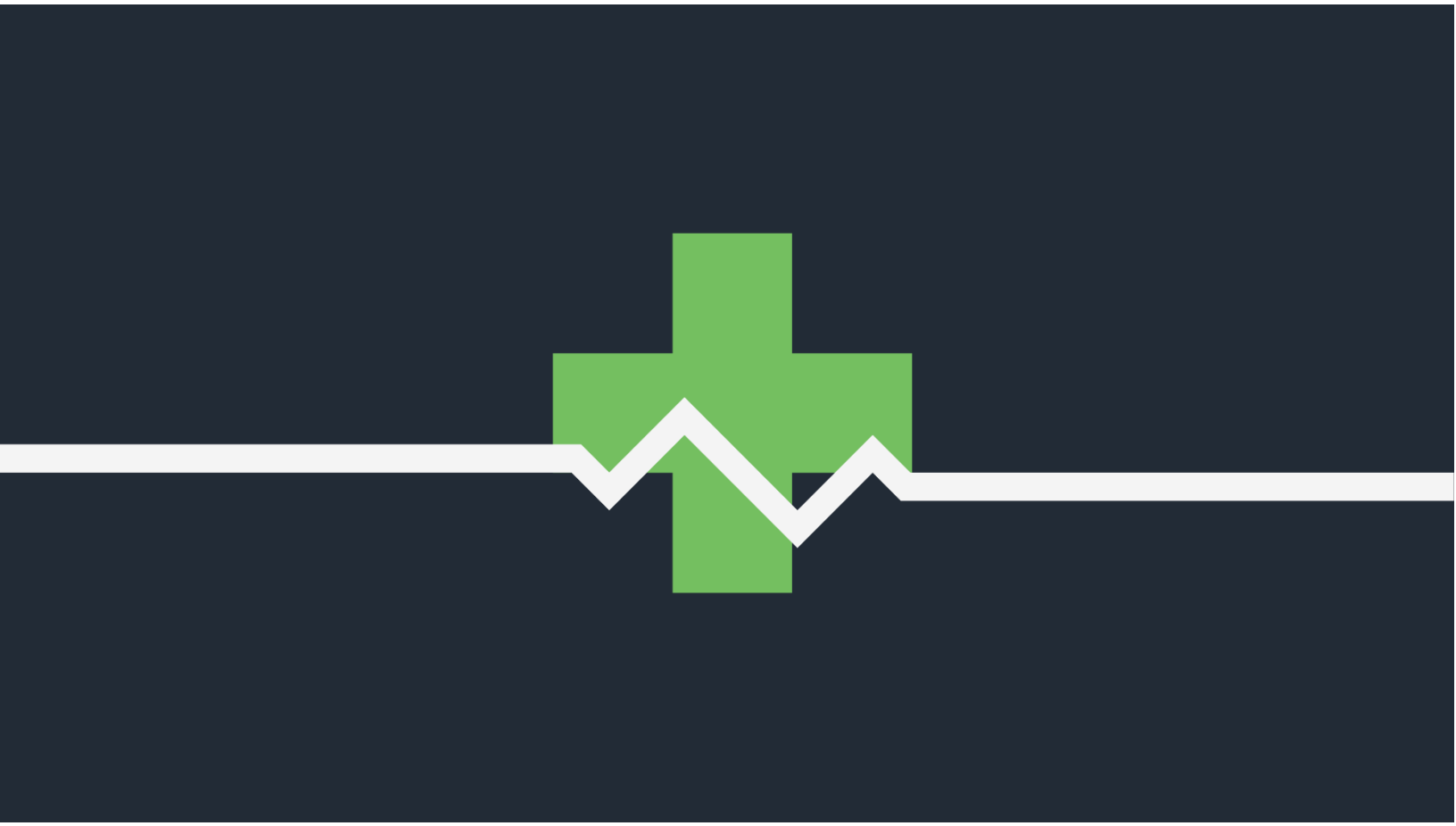
Rachin Aggarwal, MBA
Heena Arora
Hritik Jain



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Section I: Introduction

This report presents the findings of Milliman's comprehensive survey aimed at understanding the current rating and underwriting practices for group health insurance in India.

According to the Insurance Regulatory and Development Authority of India (IRDAI) Handbook on Indian Insurance Statistics 2022-23,[1] the group health insurance segment forms the largest portion of the health insurance market in India, accounting for 51.7% of the market share. The Handbook also reports that this market segment has a notably high loss ratio of 96%, meaning this market is unprofitable for participating insurers. Insurers must have accurate and efficient underwriting and rating procedures established to write this business profitably. Data-driven decisions and use of advanced data analysis are critical to develop rates in line with the experience and expected future trends. This report gives an overview of current underwriting process and productivity metrics based on a survey of industry practitioners such as underwriters, analysts, managers and other professionals who are engaged in underwriting industry in India.

SCOPE OF THE SURVEY

The survey was designed to understand the current underwriting and rating practices, underwriting team structure and involvement of the actuarial professionals in the rating of group insurance proposals in the Indian health insurance market. The survey also assessed the use of the latest tools and techniques and challenges related to data and workflow.

A questionnaire, developed by Milliman, with a focus on the current rating and underwriting practices for group health insurance in India, was used to conduct the survey. This questionnaire was distributed among 16 insurance providers.

CONTRIBUTORS

The survey was voluntary and was sent out to group health underwriters in 16 insurance companies (including general and standalone health insurers) selling group health insurance products in India. We received responses from eight insurers.

RELIANCE AND LIMITATIONS

In conducting the survey and preparing this report, we have relied upon the information provided by the contributors. It is important to note that we did not independently audit or verify information self-reported by survey participants. To the extent that this information is incomplete or inaccurate, our results may be materially affected.

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ABOUT MILLIMAN

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DISCLAIMER

This survey is intended solely for educational purposes and presents information of a general nature. It is not intended to guide or determine any specific individual situation and persons should consult qualified professionals before taking specific actions. Neither the authors, nor the authors' employer, shall have any responsibility or liability to any person or entity with respect to damages alleged to have been caused directly or indirectly by the content of this survey.

[1] IRDAI. Handbook on Indian Insurance Statistics 2022-23. Retrieved 14 March 2024 from https://irdai.gov.in/document-detail?documentId=4417599 (zip file download).

Section II: Overview of group health insurance market in India

Group health insurance plans are gaining popularity in India due to their relative cost-effectiveness. By distributing risk among a larger group, these plans reduce selection risk and administrative expenses, leading to lower premiums per capita. These plans are appealing to employers, associations and unions due to their reduced risk and financial benefits.

The summary below presents the business composition, market share and claim loss ratio of group health insurance market for the financial year 2022-23.

BUSINESS MIX

The data presented in Figure 1 shows the distribution of total health insurance premium among three categories: group, retail, and group government. The premium distribution shows that group health insurance has the biggest share of the health insurance market at 51.7%, indicating its popularity, often associated with workplace plans. Retail health insurance comes next at 38.8%, showing individual coverage needs. Government health insurance makes up 9.5% of the total gross premium in 2022-23.

FIGURE 1: BUSINESS MIX IN HEALTH INSURANCE MARKET IN INDIA (2022-23)

CATEGORY	PREMIUM (INR in Cr.) *	PERCENTAGE
GROUP	46,245.9	51.7%
RETAIL	34,765.6	38.8%
GROUP GOVT.	8,480.3	9.5%
TOTAL	89,491.8	100%

* See https://irdai.gov.in/handbook-of-indian-insurance (data retrieved on 26 February 2024.)

DISTRIBUTION OF GROUP HEALTH PREMIUM AND LOSS RATIOS BY TYPE OF INSURER

Public non-life insurers account for over half of group health gross premiums written in India. Private non-life insurers are also strong competitors, with 36% market share, and the remaining 13% is written by standalone health insurers.

Loss ratios, among other metrics, indicate how effectively risk is being underwritten and priced by insurers. Public insurers had a high loss ratio of 107% for group health in 2022-23, which may indicate significant gaps in underwriting capability, although high loss ratios may also be attributable to other factors such as competitive pricing and market share strategy. Private non-life insurers had a loss ratio of 89% and standalone health insurers showed better performance with a lower ratio of 61%, implying a closer alignment between premiums and claims.

FIGURE 2: GROSS WRITTEN PREMIUM AND LOSS RATIO DISTRIBUTION FOR GROUP HEALTH BY INSURER TYPE (2022-23)

INSURER TYPE	PREMIUM (INR IN CR.) *	PERCENTAGE	LOSS RATIO*
PUBLIC NON-LIFE INSURERS	23,418.3	51%	107%
PRIVATE NON-LIFE INSURERS	16,638.6	36%	89%
STANDALONE HEALTH INSURERS	6190.0	13%	61%
TOTAL	**46,245.9**	**100%**	**96%**

* See https://irdai.gov.in/handbook-of-indian-insurance (data retrieved on 26 February 2024.)

Given the considerable size of the market and poor overall performance, it is helpful for stakeholders to understand the current market and best practices.

Section III: Survey highlights

In this section, we present some key findings and insights from the survey responses. We summarised the outcomes of *eight* Insurance companies that participated in the survey.

HIGHLIGHTS

- There is a significant variation in the number of quotes handled monthly, the gross premium underwritten and the size of the underwriting teams across different insurers.
- Team sizes varied from eight to 54 full-time employees (FTEs), with quotes per FTE ranging from 175 to 2,400 monthly.
- Certain insurers with lower business volumes operate with larger teams, while those with higher business volumes typically handle more proposals and underwrite higher premiums per full-time employee annually. This indicates the use of different operational strategies within the industry.
- However, the survey results suggest a relationship between the volume of group health insurance proposals, the total premium underwritten and the size of the underwriting team, which indicates that few insurers have found ways to fully automate the process. More premiums typically means more human FTEs to process quotes, even while there are wide variations in productivity.
- The survey results reveal that the structure and size of underwriting teams vary significantly among respondents. This includes a varying number of junior underwriters in the team, with some respondents opting not to include this position.
- The composition of teams also differs widely, with some companies having a larger team of senior underwriters, while others had more data entry analysts. Additionally, a few respondents mentioned the use of interns and medical doctors within their group underwriting teams.
- The survey reveals that, in the field of group health underwriting, half of the respondents collaborate with the actuarial team to set prices, using a tool for initial quote generation and adjusting the quote based on the size and complexity of the proposal. The rest allow the underwriting team to independently manage quote generation, with the actuarial team overseeing portfolio performance.
- As per the responses received, there is a clear variation in the time taken to supply quotes. While some insurers can supply the first quote within a day, others may take up to five days. For subsequent quotes, the turnaround time tends to be quicker, typically ranging between one to two days.
- The survey responses highlight the wide-ranging data used for pricing group cover, with insurers utilising both aggregate and detailed experience data, emphasising the importance of historical claim and membership patterns. Demographic factors such as age, gender and, for other insureds, relationship to the primary policyholder are universally considered in pricing strategies. Most insurers also consider target loss ratios as well as the premium details of the plans that are nearing their expiration date or expiring.
- Insurers report using a diverse range of methods to establish final quotes. Most insurers use benchmarks as part of their data inputs when formulating quotations. Many also consider competitor pricing as a crucial factor in finalising quotes, and many include premium quotes from actuarial tools.
- Insurers use different pricing methods for large groups compared to small and medium ones. For new business, they often resort to actuarial book (portfolio) rating while, for renewals of larger groups, they consider actual claim experience from other insurers. Some segment pricing based on employee count and use different rating tables for each category. Smaller groups often use exposure-based methods or calculators for quoting, with adjustments made during renewal considering factors like coverage and claims.
- The key data-related challenges faced by most of the insurers are about the quality of claim experience data available and membership data being available only at aggregate level. The diversity in data maintenance practices among third-party administrators was also highlighted as a significant challenge.
- “No/less flexibility to model/rate multiple benefit options for the same proposal” appears to be the biggest rating model-related challenge faced by the insurers.

- Many insurers do not use any software for group health underwriting while a few insurers use either commercial or in-house software for this purpose. Proposal queue management, quote generation and approval matrix, communication management and integration of actuarial models are the key features used by most of the insurers where commercial software is used.
- Most of the insurers update their actuarial rating models annually, in line with best practice.
- Manual assignment of proposals, reliance on emails, nonstandard underwriting decisions and capacity constraints seem to be the main workflow-related challenges as reported by the insurers.

Section IV: Detailed analysis of responses

This section provides detailed analysis of the responses received by all the contributors and is divided into subsections, i.e., underwriting and rating, to gain better understanding of these processes.

UNDERWRITING

Proposals and quotes

- We asked respondents to share insights into the number of group health proposals they have underwritten in the last one-year period, including the number of quotes generated.
- The responses show a range of workloads across underwriting teams and the scale of underwriting activities within the industry. Based on the responses of seven respondents out of eight (one of the respondents skipped the question), the range of monthly quotes varies from 500 to 4,000 in number.

Underwriting team

- The underwriting teams of the surveyed insurance companies consist of junior underwriters, senior underwriters and data entry analysts. These teams play crucial roles in the underwriting process.
- For insurers with larger underwriting teams, junior underwriters often make up the majority of team members, with some companies having as many as 30 individuals in this role, which constitutes 56% of the total team. However, some teams choose not to include junior underwriters at all. Similarly, the composition of senior underwriters and data entry analysts varies among companies. Some employ up to 20 senior underwriters, accounting for 37% of the total team, and some employ 10 data entry analysts, making up 43% of the team.
- In addition to data entry analysts, underwriters and support from the actuarial team, insurers also employ interns in their underwriting teams. One of the respondents also mentioned the inclusion of medical doctors in its underwriting team, although this practice does not appear to be widespread.

Please note that we have observed a high variation in the number of quotes, gross premium written and FTEs employed, which possibly could be due to incorrect information shared by the respondents, or because teams are deployed across multiple other processes besides underwriting.

Group health underwriting process

- We asked the respondents to share information regarding their current processes for group health underwriting. The responses from the insurers regarding their current group health rating and underwriting processes reveal a balanced distribution between the provided options.
- Fifty percent of the respondents prefer to collaborate with the actuarial team when setting prices. They use a tool to generate an initial quote, which is based on the proposal's size and complexity. They then adjust this quote, applying discounts or additional charges as needed to reach the final price. For new proposals or large accounts, they often seek assistance from the actuarial team.
- The other half of the insurers allow the underwriting team to manage the entire process of generating quotes independently. In these cases, the actuarial team's role is to monitor the overall performance of the portfolio, rather than being involved in the daily task of quote generation.

Average turnaround time for providing qoutes

- Among the insurers that responded to the survey, there is a range of average turnaround times for providing both the first and subsequent quotes.
- While some demonstrate a quick turnaround, delivering the first quotes within a day, others take a more extended period, extending up to five days for the initial quote. Similarly, the turnaround time for subsequent quotes ranges from less than one day to three days.

Challenges faced during underwriting process

Data-related challenges

- Half of the respondents worried about the limited availability of membership data, highlighting that it is only accessible at an aggregate level.

- Furthermore, 75% of insurers identify subpar quality in claim experience data as a significant hindrance to using this data for rating analysis. One respondent cited challenges related to data availability and the absence of readily accessible internal experience data for renewing clients.
- One respondent called out the diversity in data maintenance practices among third-party administrators (TPAs) as a notable challenge.

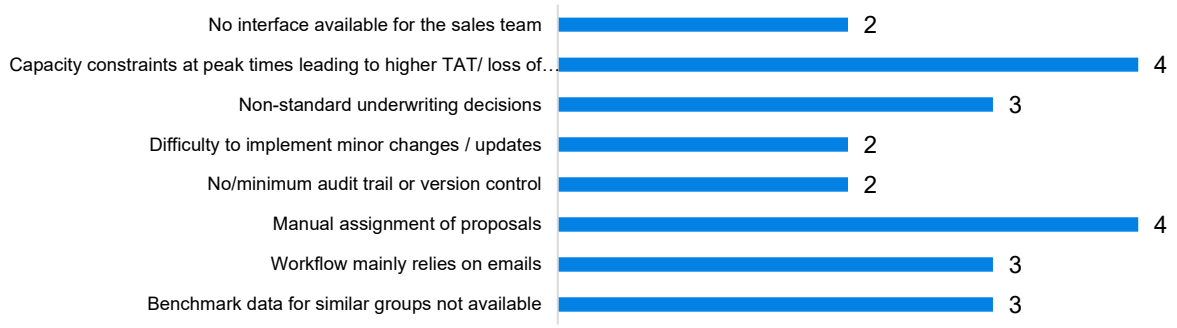
Rating model-related challenges

- Six insurers responded to this question and revealed a range of challenges in their rating models. Notably, five expressed concerns about the limited flexibility to model or rate multiple benefit options for the same proposal.
- Two respondents identified a reliance on the actuarial team for quote provision as a bottleneck, slowing down the rating process, while another two highlighted the susceptibility of their models to errors. Implementing strong error tracking and validation mechanisms is essential for ensuring the accuracy and reliability of rating models, regardless of the type of tool or model used.
- These insights underscore the importance of enhancing flexibility, error mitigation and overall efficiency in rating models to improve the underwriting process.

System/workflow-related challenges

- The survey findings, based on six responses, indicate that insurers face several challenges in their systems and workflows. Notably, four expressed concerns about issues such as manual assignment of proposals and capacity constraints during peak times, leading to longer turnaround times and potential business loss.
- Additionally, half of the respondents pointed out challenges related to the absence of benchmark data for similar groups and reliance on emails for managing workflows as a significant hurdle. Two respondents identified difficulties in implementing minor changes or updates in the workflow processes, citing the lack of an interface for the sales team and minimal or no audit trail or version control as key obstacles.
- To tackle these challenges, insurers may consider investing in automated workflow tools, implementing robust audit trails for better version control and finding ways to facilitate smoother interactions between underwriting and sales teams. These measures have the potential to enhance efficiency, reduce manual workload and improve overall underwriting processes.
- Figure 3 provides a visual representation of the key system and workflow-related challenges that insurers face, as revealed by our survey findings.

FIGURE 3: SYSTEM AND WORKFLOW-RELATED CHALLENGES



Rating

GROSS PREMIUM

- We asked the respondents to share the gross premium underwritten by their underwriting teams in the recent one-year period.
- Two of the insurers refrained from disclosing specific numbers, while those providing numerical values reported a wide range, from 1,000 crores to 4,000 crores.

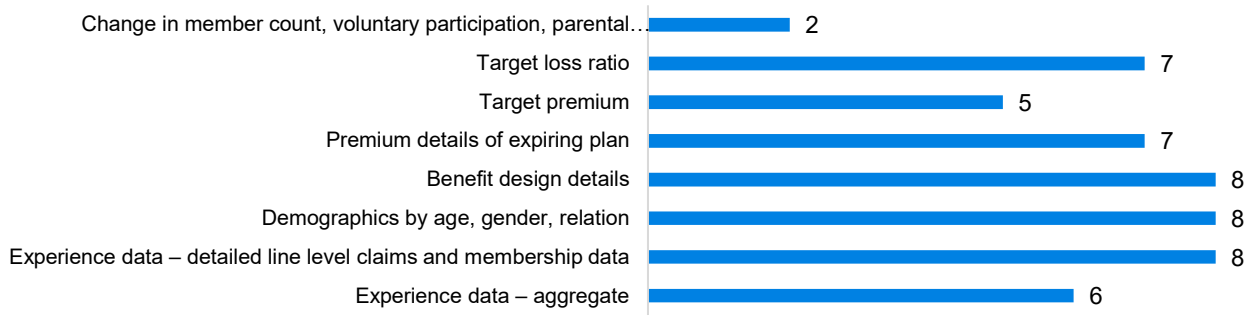
QUOTE ANALYSIS REFERENCES

- The responses also provide insights into the different analyses and references used for arriving at the final quote.
- A majority of respondents prioritise using benchmark data for similar groups or size as one of the key reference points. Most rely on competitor-driven pricing, emphasising not only the significance of market dynamics in determining target premiums, but also the risks of underpricing to build their overall premiums.
- Additionally, only half of the respondents used premium quotes generated from actuarial rating tools, highlighting the role of more analytical advanced tools such as group underwriting systems, which can offer more precise and data-driven pricing strategies, potentially improving accuracy and market competitiveness with respect to the pricing process for some insurers.

INFORMATION USED FOR PRICING

- The responses from the surveyed insurers provide an overview of the diverse set of information and data used for pricing a group cover, with all respondents using both aggregate and detailed experience data, emphasising the importance of historical patterns in claims and memberships.
- Demographic factors such as age, gender and relation to employee play a vital role, with all respondents considering this information in their pricing strategies. Most of the insurers surveyed used target loss ratio and premium detail of expiring plans as crucial factors for setting prices.
- Notably, around 25% of respondents go beyond the standard options, including additional factors such as updated enrolment and claim data, as well as considerations like changes in member count, previous policy schedule and requests for proposal (RFPs) from brokers.
- Figure 4 demonstrates the diverse data and information used by insurers for group cover pricing, highlighting the importance of aggregate and detailed experience data, demographic factors and other additional factors as mentioned in the above point.

FIGURE 4: INFORMATION USED FOR PRICING



GROUP PRICING APPROACHES

- Among the six responses on methodology, it is evident that insurers use distinct approaches for large group pricing, highlighting variations from small and medium group pricing strategies.
- For new business, one of the respondents mentioned an approach which involves actuarial rating and incorporating specified factors. In contrast, renewals for larger groups involve investigating the actual experience, the frequency and the average size of claims across age bands.
- Additionally, one respondent mentioned the adjustment of pricing for portfolio trends during the proposal stage.
- In addressing large group pricing, one of the respondents mentioned categorizing large group pricing based on employee count: micro/small (less than 100), medium (101-500) and large (over 500). They use different rating tables and credibility factors for each category, maintain consistent pricing across channels and apply strict underwriting criteria based on proposal quality and identified risks.
- Notably, differences emerge based on group size, with small groups (up to 300 lives) often relying on exposure-based methods, employing rate cards or utilising over-the-counter (OTC) calculators for quoting.
- Referring to a specific threshold, the use of experience rating tables was also mentioned by one of the respondents. Further adjustments are made during renewal, considering factors such as coverage and claims.

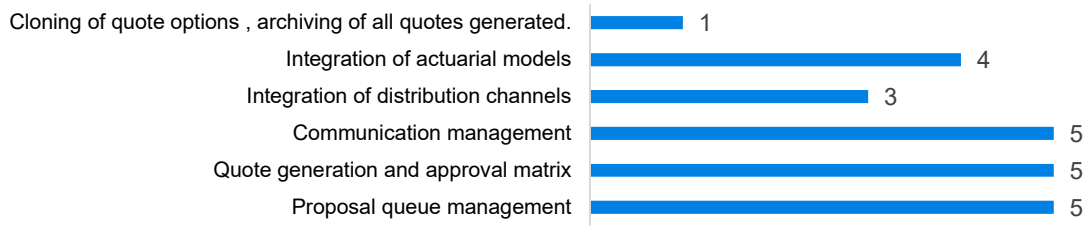
ACTUARIAL MODEL UPDATE FREQUENCY

- Most insurers are updating their actuarial rating models every year, ensuring that the model is current and relevant; however, one is updating only every other year.
- This annual update strategy emphasises accuracy and is considered as best practice in the industry, ensuring that actuarial models stay robust and responsive to evolving factors in the insurance landscape.

NAVIGATING GROUP HEALTH QUOTES: SOFTWARE INSIGHTS

- The responses from insurers reveal that approximately two-thirds of respondents are not currently utilising any automated software for their group health underwriting processes. In contrast, one of the respondents indicated the use of commercial software for these purposes and two respondents indicate the use of in-house software.
- Most respondents expressed a preference for software to automate quote generation and approval matrix functionality, proposal queue management and communication management. Additionally, one-third of participants highlighted the importance of integration of distribution channels. Meanwhile, half would like to integrate and automate actuarial models.
- The diverse range of features, including cloning of quote options and archiving of generated quotes, is mentioned by one respondent as desirable functionalities it would like to have in its underwriting software.
- These insights suggest a demand for comprehensive software solutions that can streamline proposal management, enhance communication processes and seamlessly integrate with various distribution channels, reflecting the software needs and preferences of insurers.
- Figure 5 illustrates the insurers' preferred software features, emphasising the need for automation, communication management and channel integration.

FIGURE 5: SOFTWARE PREFERENCES



Section V: Conclusion

The survey brings attention to the varied strategies employed by insurance companies in handling group health applications, with distinctions based on the size of the business they underwrite. These differences encompass proposal volumes, underwriting performance, team structures and procedures. The survey also exposes variations in the speed of quote delivery and the information utilised for pricing group plans.

The survey results highlight the importance of standardising team structures and implementing comprehensive training programmes, including cross-training, to ensure a well-rounded understanding of the underwriting process. An approach to underwriting, involving regular input from the actuarial team, is crucial for accurate pricing and risk assessment. The results also emphasise the need for automated systems to improve quote turnaround time and customer service. They also underscore the need for flexible rating models, a shared platform for smoother team interactions and collaboration for benchmark data. While using this data, insurers' own risk tolerance and financial objectives should be considered. The use of actuarial rating tools, different rating tables for large group pricing and annual updates to rating models are also important.

Additionally, the results shed light on challenges related to workflows and systems, such as issues with data, concerns about pricing models and operational complexities. This underscores the importance of enhancing data quality with standardised templates, adopting adaptable pricing models and streamlining workflows. Technological solutions, such as improvements in data recording systems and advanced quote management systems, emerge as potential remedies for these challenges.

Given that the group health market remains a significant contributor to insurers' overall health portfolios, and the large aggregate losses resulting from high loss ratios for this segment, a strategic review of current practices and processes is crucial. Identifying efficiency gaps and implementing a more robust system is essential for managing this segment effectively.

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CONTACT

Rachin Aggarwal
rachin.aggarwal@milliman.com

Heena Arora
heena.arora@milliman.com

Hritik Jain
hritik.jain@milliman.com